# ARC 4430C

# HUMAN SERVICES DEPARTMENT[441]

**Adopted and Filed**

**Rule making related to consumer choices option**

The Human Services Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

*Legal Authority for Rule Making*

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

*State or Federal Law Implemented*

This rule making implements, in whole or in part, Iowa Code section 249A.4.

*Purpose and Summary*

These amendments make several changes to the Consumer Choices Option (CCO) program available within the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, and physical disability waivers. The amendments consolidate the CCO service description rules into one subrule, 78.34(13). The amendments change the monthly budget billing methodology for the financial management services (FMS) provider from a prepay method to a postpay method. The amendments clarify who may self-direct services. The amendments also clarify the budget and employer authority responsibilities and define how the monthly CCO budget may be used by a member self-directing services. The amendments make technical changes to remove the references to the Department service workers who are no longer involved in the CCO program. Finally, the amendments add new member and employee responsibilities to ensure proper payments for CCO services are made.

*Public Comment and Changes to Rule Making*

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on February 13, 2019, as **ARC 4288C**. The Department received comments from seven respondents during the public comment period. The comments, which have been lightly edited to correct cross references and typos and make other similar nonsubstantive corrections, and the Department's responses are as follows:

**Comment 1:** I see an issue with the proposed 78.34(13)"m"(5), the part where it states, "When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service."

This makes sense if a paper time sheet was used and it was faxed or scanned/emailed to Veridian. This seems to indicate that if the timecard was mailed, the employee wouldn't be required to keep a signed copy; that's unclear to me. Also, many people use web entry timecards, nothing to save. There is a portal for employees to enter hours and for employers to approve the entries. After entered by employee and approved by employer, FMS is then able to extract them for payroll; in this case, there is nothing to retain, but it is electronic format. This seems clear but impossible without the system being updated to include an option for it.

**Department response 1:** Subparagraph 78.34(13)"m"(4) requires a CCO employee to use Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, to document employee time worked. This is the document of record for the CCO program. Information from the Consumer Choices Option Semi-Monthly Time Sheet may be submitted electronically to the FMS provider for payment and processing, but the Consumer Choices Option Semi-Monthly Time Sheet must be completed by the employee and then signed and dated. Even though the FMS electronic web entry system is used for

submitting time sheets, the Consumer Choices Option Semi-Monthly Time Sheet must be completed to support the electronic timecard submission.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 2:** I have a comment about 78.34(13)"m"(4). I have been involved in CCO for over eight years and have never known about the information in 79.3(2)"c"(3). This is welcome knowledge. I think this is great to include here in the CCO rules. However, I think this needs to be easily accessible by all employers and employees. I think it should be part of the member and employee packets. Having it accessible on the FMS and Iowa Medicaid Enterprise (IME) websites would be great also. The common person does not know where to find this info. People must know about these rules before they can follow them. I have always referred employees and employers to ask their case managers what they expect for documentation, and the answers vary; case managers having this info readily available would be great also.

**Department response 2:** This is a new provision to specify that the documentation for CCO must adhere to subparagraph 79.3(2)"c"(3). Previous rules in CCO were not specific to the documentation requirements in 79.3(2)"c"(3). The provision was added to clearly identify the documentation rule requirement for CCO. The Department agrees that the documentation requirements in 79.3(2)"c"(3) should be incorporated into the employee packets.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 3:** I noticed in 78.34(13) six waivers are listed, but when it breaks down which services are allowed with each waiver, there are only five waivers listed, the health and disability waiver is not listed.

**Department response 3:** The proposed CCO rules use the health and disability waiver rules found in rule 441—78.34(249A) as the base for all CCO rules. The CCO rules applicable to the AIDS/HIV, brain injury, elderly, intellectual disability, and physical disability waivers refer back to rule 441—78.34(249A). The CCO services for the health and disability waiver are found in subparagraph 78.34(13)"b"(1). There is no change to that subparagraph, and as such, it was not included in the Notice as a rule change for public comment.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 4:** I cannot make sense out of the fees in 79.1(2). It says rate set by member. It has been my understanding that the Department sets the rate for CCO and the managed care organization (MCO) cannot go below that set rate. I do see that the rates I can understand are much higher than the rates for CCO. I read several places where it refers to CCO being cost neutral. As an independent support broker (ISB), we have to rely on the MCOs to get the current rates and our only source of information from the MCO comes from the case managers, and many of those are confused on how CCO works. Could rates for CCO possibly be reevaluated to make them more cost neutral?

**Department response 4:** The basis of reimbursement for self-directed personal care, self-directed community supports and employment and individual-directed goods and services in subrule 79.1(2) is the "rate negotiated by member." This means that the member has the authority to set the wages of the employees and to determine how much the member will pay for goods and services. This rule has not changed.

Subparagraphs 78.34(13)"b"(8) through (12) determine how the monthly CCO budget amount is created based on the services that are authorized in the member's service plan. The individual service rates for use in CCO are calculated by IME. The calculated rate for each service is shared with the MCOs for use in creating the monthly CCO budget for the members the MCOs manage. The MCOs use the same rates that are used for the fee-for-service (FFS) members that are managed by the Department. Once the monthly budget amount is established, the member may negotiate rates with employees and service providers to meet the member's needs.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 5:**

(1) There are inconsistencies with CCO forms; example I have is the ISB fee. If you print out the ISB agreement from the IME website, the form says maximum pay is $15.00. If you print it out from the Veridian website, the MCO ISB agreement says $15.91 and the IME ISB agreement says $15.15. If you look at the monthly CCO budget, it states the max is $15.91. The MCO United Health Care (UHC) says it's $16.07, and the MCO Amerigroup says it's $16.09. I believe it is $16.07. It would be great if that was consistent information. When ISB fills out the form for a monthly budget and it states that the max is $15.91 and we enter $16.07, that seems like an integrity issue, but we have no way of changing the $15.91 on the form.

(2) ISB training is not relevant to what we are expected to do, and there is much gray area. IME and each MCO have different expectations, and all claim they cannot direct us and we must refer to our training; however, the training is vague. There is also no current way for the ISBs to get updated information.

(3) The next issue is with the ISB payroll. We are considered vendors and expected to do our job in completion each month, no matter how much time it takes. We receive a 1099 at the end of the year and are considered contract labor. But we turn in a time sheet and are paid by the hour. It seems to me that as a vendor, we should be paid a set rate each month like Veridian. That would take care of all the issues I had in (2). We have to do our job or none of the employees get paid. The budget being submitted and approved and the employees getting paid correctly are proof we did our job. When I read Iowa labor laws, it seems to me that we are contract labor and should be paid for the job, not the hour.

(4) We have recently been notified in the form of a "reminder" that we cannot use electronic or photocopied signatures. I was never notified of this, so I do not consider it a reminder. I believe there are federal laws making digital signatures legal. Also, I email a consumer and they print, sign and email back to me, so when we print it out again, it is a copied signature. If I were to drive to the member for each signature, I would need more than 2.5 hours a month. Driving two to three hours round trip for a signature does not seem an efficient use of time. I know other Medicaid papers are digitally, electronically and copy signatures. Case managers have consumers sign on their tablets. Doctors' offices have members sign on tablets. Veridian sends out the member packet to be filled out with their signatures already copied on them. I know there are people being investigated for copied signatures. Isn't the purpose of our signature to indicate we agree with what the document says, so wouldn't the person who signed be the only one who should object to the signature?

(5) I also believe Veridian has a rule that is a violation of labor laws. If someone doesn't get their time sheet turned in within 30 days, they don't pay it. I understand it gets hard when people don't turn in time sheets on time, but I don't think they cannot pay them. If Veridian doesn't pay the employee, then the employee can file a complaint with the labor board, but the complaint would be against the employer and the employer has no control over that.

(6) An ISB pays a maximum of $40.18 a month for a consumer; if someone was going to run a scam for money, ISB is not a good choice. We usually do it for more of a service because we care about the members of our community. When I started as an employee, there were no ISBs in my area. We had to search so hard for an ISB, I decided I would become an ISB for others. Many ISBs have family members that are consumers. ISBs are even more important now that we have MCOs and the case manager works for the MCO; sometimes the ISB is the only voice to advocate with the member. It seems that people that work with disabled and elderly members are very compassionate, and CCO is a way for the state to save money by taking advantage of that compassion.

**Department response 5:** The comments are not directly related to the proposed amendments in **ARC 4288C**. The respondent was referred to the correct venue to address these concerns.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 6:** Please clarify who a "service worker" is. I am my son's direct care provider and his medical power of attorney and help answer the questions on the assessment because he can't! Are you trying to cut out parents in this important process because privatized case managers do NOT know our kids or their needs!! This is illegal.

**Department response 6:** Department of Human Services service workers were previously involved in authorization of CCO services in a member's service plan. As noted in the summary section of **ARC 4288C**, one purpose of the proposed rule amendments was to "make technical changes to remove the references to the Department service workers who are no longer involved in the CCO program." The removal of the term "service worker" in the rules is in reference to Department service workers and not to a direct service worker of the member.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 7:** I am a little concerned about the implications and unintended consequences of the new rule roll out. Has it been vetted by families that use CCO? How is calendar year going to be tracked? Is the onus of responsibility on the family to know when their year ends in order to use saved time before it is reset?

I am not one to fear all change, but I would like a public meeting held so that brains bigger than mine might foresee how it affects families.

**Department response 7:** The change to the time span for creating and using a savings plan is designed to coincide with the member's service plan year. The use of a CCO savings plan, as well as all CCO services, should be addressed at the annual service plan meeting with the member's case manager or community-based case manager.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 8:** I am co-guardian of a Medicaid member who utilizes the CCO program. This program has been exactly what she needs and is an example of thinking outside of the box to provide services in a unique and individualized setting.

I do not want any rule changes that would restrict or increase the administrative burden of this program. This may decrease availability and user groups. This program offers members the flexibility they want as well as a cost savings to the State of Iowa since CCO reimbursement rates are less than that of ICF-ID or HCBS SCL services rates, both per-unit and daily rate.

I would request that there is more training provided to the administrators of the program similar to IME training for other programs. In addition I believe the CCO rates should be reviewed and increased in similar fashion as the other settings and their reimbursement rates.

**Department response 8:** The proposed amendments in **ARC 4288C** were included to:

- Change the payment methodology for the FMS,
- Clarify the roles and responsibilities of members when taking on the budget and employer authorities, and
- Clarify the responsibilities of the member and the employee to ensure program integrity within CCO.

Some changes to the responsibilities for the member and employee may increase the administrative burden of members or their representatives but are needed to ensure the integrity of the CCO program.

It is anticipated that the amendments will require additional training to implement the changes statewide, including training for ISBs, case managers, MCOs and the FMS.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 9:** The respondent requested clarification to the proposed amendments as follows:

(1) Subrule 78.34(13): In this section there are multiple references to the service of basic individual respite care. [The respondent] would like to note that the service of group respite is no longer included as a service description and is still being used by current CCO members. It would be advised that a plan be put into place to transition these members from group respite to individual respite prior to the adoption of these new rules.

(2) Paragraph 78.34(13)"h," employer authority: This section indicates the member has the authority to be the common-law employer. It further explains the employer authority tasks may be delegated if the member is a child or an adult member who cannot complete the employer authority tasks. Would the delegation of the employer authority tasks also include the delegated person being the enrolled employer

of record with the Internal Revenue Service (IRS)? [The respondent] would recommend this language clearly state who is the employer of record with the IRS.

(3) Subparagraph 78.34(13)"l"(18), responsibilities of the financial management service: This section indicates the Department may request that the financial management service provider withhold payments from the member's employee to offset any overpayment. It must be noted that the financial management service provider must comply with the laws regarding an employee's pay. [The respondent] would need the Department to provide a signed document with the employee's signature authorizing these funds to be withheld before [the respondent] could offset these payments.

(4) Item 8, rescind and reserve subrule 79.1(9): This section rescinds the subrule that outlines how the FMS organization will receive payment for the services provided to the CCO member. There are fundamental flaws with rescinding this subrule without proper planning and documentation as a part of this administrative rule change to address the following:

- A system in place for the FMS to be able to track member eligibility with timely notification.
- A process to provide the FMS with proper service authorizations for fee-for-service members. This could result in payments being issued and the FMS being unaware of the missing authorizations or the FMS having to delay payments with authorization issues until a resolution is in place impacting the member's service.
- The system currently in place has members assigned incorrectly between fee for service and the managed care organizations. This could result in significant payments being issued without a means to resolve these payments.
- Systems incompatibility between the state's individualized services information system (ISIS) and the state's Medicaid management information system (MMIS).
- A negotiated prepayment amount with the FMS and a negotiated administrative rate for the additional costs associated with moving to postpayment.

**Department response 9:**

(1) Group respite is not a service that can be authorized in a member's service plan to create the monthly CCO budget amount. Only basic respite can be authorized. This is not a rule change from previous CCO rules. However, a member may choose to purchase group respite services using funds in the CCO budget that come from basic respite.

(2) The provision described in (2) in Comment 9 has not changed. A common-law employer has the right to direct and control the performance of the services. The FMS will continue to be the employer of record with the tasks as described in paragraph 78.34(13)"l."

(3) The rules do not direct the FMS to disregard other state and federal laws and regulations. As needed, the FMS should have policies and procedures in place to allow the Department to withhold payment from a CCO employee.

(4) The provisions in subrule 79.1(9) designed to implement the prepay process for FMS reimbursement are no longer applicable to the FMS provider or the CCO billing process. The CCO rules are designed to have the FMS follow the same billing processes as all Medicaid providers follow as described in rule 441—79.1(249A). CCO services will be authorized in a member's service plan for payment to the FMS provider number. The authorization will allow the FMS to bill for services that are authorized after the provision of services. The FMS will take on the same risk as all other Medicaid providers and will have access to the same supports (i.e., track member eligibility, service plan authorization, etc.) as other providers.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 10:** The respondent that provided Comment 9 provided additional comments during the Administrative Rules Review Committee meeting held on March 7, 2019:

The Department did make [the respondent] aware of this proposed change. [The respondent] is not opposed to the change if the state can successfully mitigate the financial risk that will shift to [the respondent], along with the state successfully testing all the systems changes that will need to happen within the state's systems, and provide training needed prior to the effective date. [The

respondent] is concerned about the timeline of the implementation of these new rules, especially given the implementation of a new managed care organization.

**Department response 10:** The Department has been working with the respondent over the past year as the system moves from a prepay to a postpay system:

- The Department is in process of approving an escrow account for the respondent to cover three billing cycles to reduce the financial risk the respondent takes on when making payment for goods and services for the FFS population that uses the CCO program. This is being done to reduce the financial risk.
- The Department has requested and received input from the respondent on systems changes to ISIS. The respondent has been invited to assist and participate in the testing of ISIS systems changes before they go into production.
- The Department sends a monthly Medicaid eligibility file to the respondent that identifies all current FFS CCO members that are eligible for the month. ISIS upgrades have been made that allow the IME CCO program manager to develop a point-in-time list of Medicaid-eligible members. This can be requested by the respondent at any time during the month.
- The need for training has been identified and will be provided prior to the implementation of the CCO rules on July 1, 2019.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 11:** "With the exception of savings to pay Emergency Overtime." Death, illness and weather cannot be predicted or contained within any specified time. Employees are subject to emergency overtime year-round. If, in the last month of the waiver service year, an employee suffers injury or death, funds need to be available to pay existing caregivers until a new employee is approved.

**Department response 11:** The Consumer Choices Option Individual Budget (Form 470-4431) requires a member to have an emergency backup plan in place that identifies a provider(s) that is available in situations such as those identified by the respondent. The CCO individual budget emergency backup plan states:

"All consumers must have a plan for emergency situations. This emergency plan may be paid through your individual budget, but reductions may need to be made from other services on your budget anytime this is accessed. The Financial Management agency must have an employee packet completed if your emergency backup provider is to be paid."

If emergency overtime pay is needed, the member should have a plan in place to address how CCO services will continue to be provided and stay within the monthly budget amount.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 12:** [Member's name] receives a daily rate of $173 whereas HCBS and ICF/ID receives $340 to $370 per day per individual.

One hundred seventy-three dollars per day is a totally unrealistic figure to cover all expenses. Consumer-directed attendant care (CDAC) and transportation were taken away. Natural support was listed at four hours per day.

**Department response 12:** This provision has not changed and has been in rule since CCO began in 2007. Subparagraphs 78.34(13)"b"(8) through (12) determine how the monthly CCO budget amount for each service is created. Services provided by an enrolled HCBS provider or an intermediate care facility for persons with an intellectual disability (ICF/ID) have different cost structures and methods of rate development. The individual service rates for use in CCO are calculated by IME using the rate methodology in rule. The calculated rate for each service is shared with the MCOs for use in creating the monthly CCO budget for the members the MCOs manage. The MCOs use the same rates that are used for the FFS members that are managed by the Department.

CDAC and transportation are still available for use in creating a CCO budget.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

**Comment 13:** Budget should be based on fee for service.

**Department response 13:** The individual monthly budget amount is based on the CCO rate-setting methodology as noted in Department response 12. This provision has not changed.

The Department did not make any changes to the proposed amendments in **ARC 4288C** based on the comment.

One change has been made to correct the cross reference in subparagraph 78.34(13)"m"(5). No other changes from the Notice have been made.

*Adoption of Rule Making*

This rule making was adopted by the Council on Human Services on April 10, 2019.

*Fiscal Impact*

This rule making has no fiscal impact to the State of Iowa.

*Jobs Impact*

After analysis and review of this rule making, no impact on jobs has been found.

*Waivers*

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

*Review by Administrative Rules Review Committee*

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

*Effective Date*

This rule making will become effective on July 1, 2019.

The following rule-making actions are adopted:

ITEM 1. Amend subrule 78.34(13) as follows:

**78.34(13)** *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13)*"g"* and employer authority tasks identified in paragraph 78.34(13)*"h,"* or who delegates the budget or employer authority tasks identified in paragraph 78.34(13)*"i."* Components of this service are set forth below.

*a.* No change.

*b.* *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) No change.

(2) ~~The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.~~ Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) ~~In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.~~ Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) ~~The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.~~ Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) ~~Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).~~ Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.
4. Basic individual respite care.
5. Specialized medical equipment.
6. Supported community living.
7. Supported employment.
8. Transportation.

(6) ~~Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget,~~

~~all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.~~ Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

~~(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.~~

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)*"b"*(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)*"b"*(7) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

*c.* No change.

*d. Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services ~~or goods~~ that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or ~~service worker~~ community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or ~~service worker~~ community-based case manager.

(3) No change.

*e. Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) and (2) No change.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. to 22. No change.

23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.

24. Residential services provided to three or more members living in the same residential setting.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or ~~service worker~~ community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)*"b"*(11).

(5) No change.

*f. Savings plan.* A member savings plan must be in writing and be approved before the start of the savings plan by the department ~~before the start of the savings plan~~ for fee-for-service members or by the member's managed care organization for members in managed care. ~~Amounts~~ Budget amounts allocated to the savings plan must result from efficiencies in meeting ~~identified~~ the member's service needs ~~of the member~~ identified in the member's service plan.

(1) The savings plan shall identify:

1. to 4. No change.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. ~~The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month.~~ Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) ~~Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies.~~ Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. and 2. No change.

3. Be approved by the member's case manager ~~or service worker~~ or community-based case manager.

(4) All funds allocated to a savings plan ~~that are not expended by December 31 of each year shall revert to the Medicaid program~~ to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) No change.

*g. Budget authority.* The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) No change.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). ~~The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.~~

(3) Schedule the provision of services. ~~Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a~~ A contingency plan must be established in the member's service plan to ensure service delivery in the event the ~~legal representative~~ member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13)*"i."*

(5) No change.

~~*h. Delegation of budget authority.* The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.~~

~~(1) The representative must be at least 18 years old.~~

~~(2) The representative shall not be a current provider of service to the member.~~

~~(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.~~

~~(4) The representative shall not be paid for this service.~~

*h. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.

(2) Verify employee qualifications.

(3) Specify additional employee qualifications.

(4) Determine employee duties.

(5) Determine employee wages and benefits.

(6) Schedule employees.

(7) Train and supervise employees.

~~*i. Employer authority.* The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law~~

~~employer has the right to direct and control the performance of the services. The member may perform the following functions:~~

~~(1) Recruit employees.~~

~~(2) Select employees from a worker registry.~~

~~(3) Verify employee qualifications.~~

~~(4) Specify additional employee qualifications.~~

~~(5) Determine employee duties.~~

~~(6) Determine employee wages and benefits.~~

~~(7) Schedule employees.~~

~~(8) Train and supervise employees.~~

*i. Delegation of budget and employer authority.* The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)*"g"* and employer authority tasks identified in paragraph 78.34(13)*"h."* Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

*j.* No change.

*k. Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.

(3) to (11) No change.

*l. Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) and (2) No change.

(3) ~~Enter~~ Monitor and track the approved individual budget ~~into the web-based tracking system chosen by the department~~ amount authorized each month and ~~enter~~ document all expenditures as they are paid.

(4) to (17) No change.

(18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

*m. Responsibilities of the member and the employee.* A member participating in the CCO and the member's employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2)*"c"*(3), "Service documentation."

(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)*"m"*(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

ITEM 2. Rescind subrule 78.37(16) and adopt the following **new** subrule in lieu thereof:

**78.37(16)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 3. Rescind subrule 78.38(9) and adopt the following **new** subrule in lieu thereof:

**78.38(9)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 4. Rescind subrule 78.41(15) and adopt the following **new** subrule in lieu thereof:

**78.41(15)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 5. Rescind subrule 78.43(15) and adopt the following **new** subrule in lieu thereof:

**78.43(15)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 6. Rescind subrule 78.46(6) and adopt the following **new** subrule in lieu thereof:

**78.46(6)** *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

ITEM 7. Amend subrule 79.1(2), provider category "HCBS waiver service providers," paragraphs "32," "33," and "34," as follows:

**79.1(2)** *Basis of reimbursement of specific provider categories.*

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| 32. Self-directed personal care | Rate negotiated by member | Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on ~~the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department~~ 441—subparagraph 78.34(13)*"g"*(2). |
| 33. Self-directed community supports and employment | Rate negotiated by member | Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based |

| Provider category | Basis of reimbursement | Upper limit |
|---|---|---|
| | | on ~~the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department~~ 441—subparagraph 78.34(13)*"g"*(2). |
| 34. Individual-directed goods and services | Rate negotiated by member | Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on ~~the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department~~ 441—subparagraph 78.34(13)*"g"*(2). |

ITEM 8. Rescind and reserve subrule **79.1(9)**.

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